



State of West Virginia

West Virginia Board of Medicine

101 Dee Drive, Suite 103

Charleston, WV 25311

Telephone (304) 558-2921

Fax (304) 558-2084

PHYSICIAN ASSISTANT APPLICATION FOR PRESCRIPTIVE WRITING PRIVILEGES

The following information must be submitted with this application:

1. \$50.00 Fee – Cashiers check or money order only, payable to the WV Board of Medicine. No personal checks are accepted. This fee is non-refundable.
2. Documentation of current certification status from the National Commission on Certification of Physician Assistants.
3. The completed individual physician assistant formulary (pages 3, 4, and 5) initialed and signed on each page by your supervising physician(s) and signed by you.
4. An original transcript from your school showing completion of an approved pharmacology course. This transcript must be forwarded directly to our office from the school.
5. A sample of the prescription form you will be using. Do not have your scripts printed until after your sample has been approved by the Board. You will be asked to submit an original script (torn from your script pad) after the Board meets.

Incorrectly completed formulary sheets or samples of applicant's intended prescription blank will be returned to you for correction. Approval **will not** be granted until corrections have been made to the satisfaction of the Board. You **may not** write any prescriptions until you receive written permission from this Board.

You must complete this application in its entirety, including submission of supporting documents, or it will be returned to you. This will delay your request.

Board meetings are held every other month beginning in January. Applications must be completed and received in the Board office 15 business days prior to the next regularly scheduled Board meeting. Those received after this time will be held until the following Board meeting.

The DEA requires a physician assistant to have a DEA number separate from the supervising physician. You must contact the DEA directly to find out what you are required to do to obtain your DEA number. Their phone number is 1-800-882-9539.

INSTRUCTIONS FOR COMPLETING PRESCRIPTIVE WRITING PRIVILEGE DRUG FORMULARY

1. The supervising physician(s) and physician assistant shall carefully review the physician assistant rule with particular attention to those regulations to prescriptive privileges.
2. Section A drugs may be selected by a supervising physician(s) for use under 11 CSR 1B 2.13 by his or her physician assistant qualified under that section.
3. Section B drugs under this section may be selected by a supervising physician(s) for use by his or her physician assistant consistent with the requirements of Section A and additionally require direct order from the supervising physician(s) to the physician assistant during consultation at the time of the patient's examination by the physician assistant, and specifically noted in the patient's chart to be countersigned by the supervising physician(s); or on a refill prescription for a previously diagnosed and stable patient whose prescription was initiated by the supervising physician(s).
4. No drug may be used which is not included under Section A or B. Drugs followed by a parenthesis, for example (5mg. – 20), indicate maximum strength and dosage units.
5. The supervising physician(s) shall select only those drugs deemed necessary for the applicant to carry out the duties delegated by the supervisor(s).
6. The supervisor(s) shall select categories or individual drugs by placing his or her initials in the space provided. Strike through drugs not permitted by the supervisor(s).
7. The supervisor(s) and physician assistant shall sign and date at the bottom of each formulary selection page. The names should also be typed below the signatures of the supervising physician(s) and physician assistant.
8. Prescription forms used by a physician assistant must be approved by the Board of Medicine and shall follow the format set forth in the rule and the example provided by the Board. Effective June 1, 2009, it is no longer required to have drugs imprinted on the back of the prescription form.
9. Prescriptions for schedules III through V should not have the DEA number of the physician assistant written or printed on the prescription. There should be a place on the prescription for writing in the DEA number.

IF THE FORMULARY IS NOT COMPLETED ACCORDING TO THESE INSTRUCTIONS, IT WILL BE RETURNED TO THE PHYSICIAN ASSISTANT, THUS DELAYING THE PROCESSING OF THIS APPLICATION.

WEST VIRGINIA BOARD OF MEDICINE
101 DEE DRIVE, SUITE 103
CHARLESTON, WV 25311
(304) 558-2921

APPLICATION FOR PRESCRIPTIVE WRITING PRIVILEGES

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Primary Work Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

CURRENT AND/OR MOST RECENT EMPLOYMENT INFORMATION

Please list the following: all supervisors you are currently approved to work under; and each job location you have been approved to work at under each supervisor. If more space is needed, copy this page and attach to the application.

Supervising physicians:

1. _____

Job Locations (with addresses and phone numbers):

1. _____ Phone number: _____

2. _____ Phone number: _____

3. _____ Phone number: _____

2. _____

Job Locations (with addresses and phone numbers):

1. _____ Phone number: _____

2. _____ Phone number: _____

3. _____ Phone number: _____

3. _____

Job Locations (with addresses and phone numbers):

1. _____ Phone number: _____

2. _____ Phone number: _____

3. _____ Phone number: _____

Rev. 6/09

REQUEST FOR PRESCRIPTIVE WRITING PRIVILEGES

Effective with approval of this request, list all supervisors (including supervisors from page 1, if applicable) you will be writing prescriptions under and list all job locations where you will be writing prescriptions under each supervisor. If more space is needed, copy this page and attach to the application.

Supervising physicians:

Type of job location (i.e.,

clinic, hospital, satellite

clinic, physician's office):

1. _____

Job Locations (list physical address):

Telephone numbers:

1. _____

2. _____

3. _____

2. _____

Job Locations (list physical address):

1. _____

2. _____

3. _____

3. _____

Job Locations (list physical address):

1. _____

2. _____

3. _____

Employer Name & Address: _____

Rev. 6/09

WEST VIRGINIA BOARD OF MEDICINE PHYSICIAN ASSISTANT FORMULARY

Section A: CATEGORIES

(The supervising physician must initial each approved medication and sign at the bottom of this list.)

_____ Anti-anaphylactic agents	_____ Hemorrhoidal preparations
_____ Anti-asthmatic agents	_____ Hypolipidemic agents
_____ Anti-reflux agents	_____ Hypothyroid treatment agents
_____ Anti-ulcer agents	_____ Laxatives
_____ Antiarthropods	_____ Muscle relaxants (excluding
_____ Antibiotics: except chloramphenicol	benzodiazepines not listed in
_____ Antidepressants: except MAO	Section B)
inhibitors	_____ Non-narcotic analgesics
_____ Antidiarrheals	_____ Nonsteroidal anti-inflammatory agents
_____ Antifungal agents	_____ Ophthalmic preparations
_____ Antigout agents	_____ Osteoporosis agents
_____ Antihelminths	_____ Otic preparations
_____ Antihistamines	_____ Potassium supplements
_____ Antihypertensive agents	_____ Smoking deterrents
_____ Antimigraine agents (excluding	_____ Topical skin and mucous membrane
scheduled drugs; see Section B)	agents
_____ Antinauseants	_____ Urinary agents
_____ Antitussives (no Schedule III	_____ Vaccines and toxoids
permitted)	_____ Vitamins, minerals, and iron
_____ Antiviral agents (see section B for	preparations
anti-retroviral and anti-HIV agents)	
_____ Combinations of approved drugs	
_____ Contraceptives: oral, injectable,	
topical	
_____ Decongestants	
_____ Diabetic agents and supplies	
_____ Digestants	
_____ Diuretics	
_____ Estrogens and progestins	
_____ Expectorants and mucolytic agents:	
except acetylcysteine	
_____ Glucocorticoid agents	

_____ M.D.	_____ M.D.	_____ P.A.-C.
Supervisor signature	Supervisor signature	Physician Assistant Signature

_____	_____	_____
Print or type name	Print or type name	Print or type name

Date: _____	Date: _____	Date: _____
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SECTION A: SPECIFIC MEDICATIONS

(The supervising physician must initial each approved medication and sign at the bottom of this list.)

ANALGESICS (Schedule III only as listed)

_____ Schedule IV and V with limited doses per front of prescription and no refill
_____ Acetaminophen/codeine (325mg/30mg – 24) (C III)
_____ Acetaminophen/codeine elixir (120mg/12mg per 5 cc – 24 doses) (CIII)
_____ Acetaminophen/hydrocodone (500mg/5mg – 24) (CIII)
_____ Aspirin/codeine (325mg/30mg – 24) (CIII)

ANXIOLYTICS & SEDATIVES

_____ Alprazolam (0.5mg – 30) (C IV)
_____ Diazepam (5 mg – 15) (C IV)
_____ All other Schedule IV and V with dose limits per front of prescription and no refill

MISCELLANEOUS

_____ Bellergal (phenobarbital/ergotamine/belladonna alkaloids) (C IV)
_____ Durable medical equipment
_____ Oxygen
_____ Probenecid

_____ M.D.	_____ M.D.	_____ P.A.-C
Supervisor signature	Supervisor signature	Physician Assistant signature
_____	_____	_____
Print or type name	Print or type name	Print or type name
Date: _____	Date: _____	Date: _____

Rev 1/05

SECTION B:

(These medications may be prescribed by the physician assistant only after consultation with the supervising physician, or as a continuation of a treatment initiated originally by the supervising physician. The supervising physician must initial each approved medication or category, and sign at the bottom of this list.)

ANTI ALZHEIMER'S AGENTS
_____**ANTIARRHYTHMICS & CARDIOVASCULAR AGENTS (non-injectable only)**
_____**ANTICONVULSANTS**

_____ All non-scheduled agents
_____ Diazepam rectal (10mg – 2) (C IV)
_____ Phenobarbital (C IV)

ANTIPARKINSON AGENTS
_____**ANTIPSYCHOTIC AGENTS (excludes clozapine)**
_____**ANTIRETROVIRAL AGENTS/ANTI-HIV AGENTS**
_____**INFLAMMATORY BOWEL TREATMENT AGENTS**
_____**PLATELET AGGREGATION INHIBITORS/BLOOD MODIFIERS**
(excludes anticoagulants)
_____**MISCELLANEOUS**

_____ Acetaminophen/butalbital/caffeine (Fioricet) (#20)
_____ Aspirin/butalbital/caffeine (Fiorinal) (#20)
_____ Atomoxetine HCl (Strattera)

Supervisor signature M.D. Supervisor signature M.D. Physician Assistant signature P.A.-C.

Print or type name Print or type name Print or type name

Date: _____ Date: _____ Date: _____

Front of script:

NAME OF HEALTH CARE FACILITY
PHYSICAL ADDRESS OF HEALTH CARE FACILITY
PHONE NUMBER OF HEALTH CARE FACILITY

SUPERVISOR NAME _____, P.A.-C.

NAME: _____

ADDRESS: _____ DATE: _____

Rx

“Sample”

Please label

Refills 1 2 3 4 5 NR

_____, P.A.-C. _____ DEA #

This prescription may be filled with a generically equivalent drug product unless the words “Brand Medically Necessary” are written in the practitioner’s own handwriting, on this prescription form.

REVISED: 6-09

SECTION A:

CATEGORIES

Anti-anaphylactic agents
Anti-asthmatic agents
Anti-reflux agents
Anti-ulcer agents
Antiarthropods
Antibiotics: except Chloramphenicol
Antidepressants: except MAO inhibitors
Antidiarrheals
Antifungal agents
Antigout agents
Antihelminths
Antihistamines
Antihypertensive agents
Antimigraine agents (excluding scheduled drugs; see Section B)
Antinauseants
Antitussives (no Schedule III permitted)
Antiviral agents (see Section B for antiretroviral and anti-HIV agents)
Combinations of approved drugs
Contraceptives, oral, injectable, topical
Decongestants
Diabetic agents & supplies
Digestants
Diuretics
Estrogens & progestins
Expectorants & mucolytic agents: except acetylcysteine
Glucocorticoid agents
Hemorrhoidal preparations
Hypolipidemic agents

Hypothyroid treatment agents
Laxatives
Muscle relaxants (excluding Benzodiazepines not listed in Section B)
Non-narcotic analgesics
Nonsteroidal anti-inflammatory agents
Ophthalmic preparations
Osteoporosis agents
Otic preparations
Potassium supplements
Smoking deterrents
Topical skin & mucous membrane agents
Urinary agents
Vaccines and toxoids
Vitamins, minerals & iron preparations

ANALGESICS: (Schedule III only as listed)
Schedule IV and V with limited doses per front of prescription and no refill
Acetaminophen/codeine (325mg/30mg – 24) (C III)
Acetaminophen/codeine elixir (120mg/12mg per 5 cc – 24 doses) (C III)
Acetaminophen/hydrocodone (500mg/5mg – 24) (C III)
Aspirin/codeine (325mg/30mg – 24) (C III)

ANXIOLYTICS & SEDATIVES:

Alprazolam (0.5mg – 30) (C IV)
Diazepam (5mg – 15) (C IV)
All other Schedule IV and V with dose limits per front of prescription and no refill

MISCELLANEOUS:

Bellergal (phenobarbital/ergotamine/belladonna alkaloids) (C IV)
Durable medical equipment
Oxygen
Probenecid

SECTION B:

ANTI-ALZHEIMER'S AGENTS

ANTIARRHYTHMICS & CARDIOVASCULAR AGENTS (non-injectable only)

ANTICONSULSANTS:
All non-scheduled agents
Diazepam rectal (10mg – 2) (C IV)
Phenobarbital (C IV)

ANTIPARKINSON AGENTS

ANTIPSYCHOTIC AGENTS (excludes clozapine)

ANTIRETROVIRAL AGENTS/ ANTI-HIV AGENTS

INFLAMMATORY BOWEL TREATMENT AGENTS

PLATELET AGGREGATION INHIBITORS/BLOOD MODIFIERS (excludes anticoagulants)

MISCELLANEOUS:
Acetaminophen/butalbital/caffeine (Fioricet) (#20)
Aspirin/butalbital/caffeine (Fiorinal) (#20)
Atomoxetine HCl (Strattera)